benefits rulings within the Second Circuit, almost always being invoked to the detriment of elderly or disabled plaintiffs. So sweeping has been its application, and so impregnable has been the barrier to benefits created by *Pagan*, that in many instances, LSE's clients have been denied benefits that likely would have been awarded if a less deferential standard of review applied, resulting in great hardship. In a recent, still-pending case in which LSE sought *de novo* review on the basis of a conflict of interest, the district court, following *Pagan*, still insisted on applying the highly deferential arbitrary and capricious standard. *Nerys v. Building Service 32B-J Health Fund*, 2004 WL 2210256 (S.D.N.Y. Sept. 29, 2004). In view of LSE's present and on-going representation, it has a significant interest in the resolution of the questions presented in the petition for certiorari.

SUMMARY OF ARGUMENT

Amicus curiae LSE agrees with the reasons set forth by Petitioner as to why the writ should be granted and the questions presented resolved on the merits. In addition, drawing on its years of experience representing the indigent elderly in cases involving conflicted insurers, LSE points to several concerns that it believes give added urgency to the need for this Court to resolve the issues raised in the petition for certiorari.

Leaving intact the rule used to deny Petitioner's claim will perpetuate the present untenable situation in which participants and beneficiaries of ERISA-governed plans will continue to be denied benefits without ever having had the opportunity to have a "full and fair" adjudication of their claims. 29 U.S.C. § 1133 ("[E]very employee benefit plan . . . shall afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."); 29 C.F.R.

2560.503-1(h)(1) ("Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have . . . a full and fair review of the claim and the adverse benefit determination."). ERISA's statutory language and policy rationales mandate that claims denials should be reviewed by either (i) an adjudicator with no conflict of interest, or (ii) a court that does not give deference to a decision made by an adjudicator that has a conflict of interest. Any other rule would subvert Congress's principal aim in enacting ERISA: ensuring that employees and their beneficiaries receive all the benefits for which ERISA-governed plans make them eligible. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) ("ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.").

At the core of the approach according deference to conflicted ERISA "administrators" is the false premise that private insurance companies should be treated with the deference afforded public administrative agencies, rather than, as Congress intended, with the level of review appropriate to decisions of trustees. The ironic and certainly unintended result is that ERISA acts to shield, rather than root out, the self-serving behavior of conflicted insurers. Such a consequence is not only unfair, but will continue to erode public confidence in the worth of private health, disability, life, and unemployment insurance and pension benefits. Of equal importance, it will continue to erode public confidence in the ability of the federal government to protect against abuses in the distribution of private benefits.

ARGUMENT

I. Applying An Administrative Law "Arbitrary And Capricious" Standard To Decisions By Conflicted ERISA Administrators Denies Claimants Their "Day In Court" And Prevents Claimants From Receiving The "Full and Fair" Treatment That Congress Intended Them To Receive When It Enacted ERISA

A. Equating ERISA Administrators With Unbiased Federal Agencies Denies Claimants An Unbiased Adjudication On The Merits Of Their Claims

Implicit in the Seventh Circuit's use of the highly deferential arbitrary and capricious standard to uphold the termination of Petitioner's benefits is the premise that decisions made by ERISA-governed benefit plans are administrative decisions that are not qualitatively different from the decisions rendered by impartial governmental agencies.[4] This equation is reflected in the use of the term "administrative decision" to refer to the resolution by the plan administrator of disputes with its participants and beneficiaries; the term "administrative record" to refer to the evidentiary record considered by the plan administrator; and the term "administrative

---

[4] *Compare Motor Vehicle Mfrs. Ass'n. of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (remarking that under the "arbitrary and capricious" standard of the Administrative Procedure Act, "the agency must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made" and that the court must "consider whether the decision was based on a consideration of the relevant actors and whether there has been a clear error of judgment") (internal quotation marks and citations omitted) *with Miller v. United Welfare Fund*, 72 F.3d 1066, 1070 (2d Cir. 1995) (describing an ERISA determination as "arbitrary and capricious [if it] is without reason, unsupported by substantial evidence or erroneous as a matter of law").

exhaustion" to refer to the exhaustion of the claim request process. *E.g.*, *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 982-83 (7th Cir. 1999) ("Deferential review of an administrative decision means review on the administrative record."); *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 (6th Cir. 1998) ("The application of the administrative exhaustion requirement in an ERISA case is committed to the sound discretion of the district court . . . .").

This equation, however, is inappropriate and misleading, especially when the plan administrator has a conflict of interest. By any objective standard, there is a vast difference between the procedural safeguards provided by an administrative agency and a self-interested insurance company: a difference that will often decisively affect whether claimants actually receive the benefits for which they are eligible. Simply put, the adjudication of a claim by a neutral federal administrative agency—with no direct financial stake in the outcome and no fiduciary responsibility to profit-motivated shareholders—is vastly more likely to lead to a fair decision than a claim processed by a plan administrator with a conflict of interest. *See generally* Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 John Marshall L. Rev. 727 (2004). *Cf. Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (Posner, J.) ("Pension fund trusts are not administrative agencies and most of the decisions they make are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers. Certainly in a case such as the present one, pension fund trustees are not policy-makers; they are interpreters of contractual entitlements.").

This Court has recently described the safeguards available in federal agency adjudications:

> There can be little doubt that the role of the modern federal hearing examiner or administrative law judge . . . is 'functionally comparable' to that of a judge. His powers are often, if not generally, comparable to those of a trial judge . . . . *More importantly, the process of agency adjudication is currently structured so as to assure that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency.* . . . Federal administrative law requires that agency adjudication contain many of the same safeguards as are available in the judicial process. The proceedings are adversary in nature. They are conducted by a trier of fact insulated from political influence. . . . The parties are entitled to know the findings and conclusions on all of the issues of fact, law, or discretion presented on the record.

Federal Maritime Comm'n v. South Carolina State Ports Auth., 535 U.S. 743, 756-57 (2002) (internal citations and quotation marks omitted) (emphasis added).

By contrast, Petitioner's claim was denied by an insurance company that was anything but "functionally comparable" to a federal judge. Nor was the treatment he received substantially equivalent to that provided a federal agency claimant. "[I]mportantly," the company did not provide Petitioner with a "process of agency adjudication . . . structured so as to assure that the [decisionmaker] exercise[d] his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency." *Id.* at 756. All of the individuals with decision-making authority with respect to granting or denying Petitioner's claim were employees of the company and dependent on the company

for their livelihood. Pet. App. 11a-12a, 51a, 92a-94a. Had they decided to grant Petitioner's claim, it would have been paid, not from a separate trust, but out of the company's general assets. *See Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1561 (noting that insurance companies are exempted from the usual requirement under ERISA that plan assets be held in a separate trust). In denying the claim, the company benefited its own financial interests and those of its shareholders to whom it owes a fiduciary obligation. *See id.* at 1564 n.1 ("[T]he individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies."). Had the company granted the claim, it would have acted against these financial interests. *See id.* at 1561 ("Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business."); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000) ("[T]he typical insurance company is structured such that its profits are directly affected by the claims it pays out and those it denies.").

Nonetheless, when reviewing the insurer's decision, the district court and Seventh Circuit upheld the denial of benefits using essentially the same highly deferential "arbitrary and capricious" test that they would have used in reviewing administrative agency decisions—that is, decisions rendered by unbiased, expert administrative agencies that provide claimants with a raft of attendant safeguards. As this Court noted in *Federal Maritime Commission*, those safeguards are substantially the same as those provided by trial judges. Because administrative agencies provide those protections, trial courts are not necessarily acting unfairly when they review agency decisions with the same deference that appellate courts often use to review trial court decisions; in both situations the deferential review takes place *after* a proceeding in

which the plaintiff or appellant has been provided with either a trial or trial-like safeguards, including having the decision rendered by an adjudicator—be it a judge, a jury, or an administrative law judge—who has no conflict of interest. In both situations the person seeking relief has a meaningful "day in court."

The situation for Petitioner was the exact opposite. At the time he filed suit, he had not already enjoyed the fair treatment that administrative agencies provide to claimants, including the basic procedural safeguard of having his case decided by an adjudicator without a conflict of interest. In according a high level of deference to the insurer's decision in this case, the district court and the Seventh Circuit failed to afford Petitioner the fundamental fairness that Congress wanted beneficiaries to enjoy when it enacted ERISA. Petitioner never had his day in court.

B. The Statutory Provisions Of ERISA Offer No Basis For According Conflicted ERISA Administrators Deference Under An "Arbitrary And Capricious" Standard Of Review

The treatment by the courts of suits brought under ERISA as if they were requests for judicial review of federal agency decisions runs squarely counter to the manner in which Congress intended ERISA to be enforced. The statutory mechanisms for enforcement applicable to a denial of benefits or breach of fiduciary duty under 29 U.S.C. § 1132(a) do not provide participants or beneficiaries with relief in an administrative agency. ERISA actions under Section 1132(a) allow relief to be sought solely from courts. 29 U.S.C. § 1132(a) ("A *civil action* may be brought . . . .") (emphasis added). Moreover, Section 1132(a) uses none of

the language found in statutes authorizing suits in the nature of appeals of agency decisions.[5]

Had they wished to indicate such an intention, the drafters of ERISA could have easily done so by inserting language of this kind. But this was not their intent, as is revealed by the statute's "carefully crafted and detailed enforcement scheme." *Mertens v. Hewitt Associates*, 508 U.S. 248, 254 (1993) (citation omitted). Rather than employing the conventional language of administrative law,[6] "ERISA abounds with the language and terminology of trust law." *Firestone*, 489 U.S. at 110. When district courts preside over ERISA suits, they do not sit as courts of appeal, but as courts of equity protecting the interests of trust beneficiaries. George G. Bogert & George T. Bogert, *Handbook of the Law of Trusts*, ch. 18 (5th ed.

---

[5] For example, unlike the judicial review provisions of the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, Section 1132(a) does not refer to the court in which an ERISA claimant seeks redress as a "reviewing court." *Id.* Nor, unlike the APA, does it have an explicit limitation of *de novo* review only to facts that "are subject to de novo review," 5 U.S.C. § 706(2)(F), a limitation that permits *de novo* judicial review of adjudications only if the "agency's factfinding procedures are inadequate." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415 (1971). Nor, unlike the APA, does section 1132(a) contain language indicating the legislature's intention to create only limited judicial review in the form of an "appeal" of agency action. 5 U.S.C. § 706(2)(A).

[6] In the debates preceding the enactment of ERISA, Congress considered an amendment providing for benefit disputes to be brought before "hearing examiners . . . appointed pursuant to the Administrative Procedure Act." 2 Subcommittee on Labor of the Senate Committee on Public Labor and Public Welfare, 94th Cong. 2d Sess., Legislative History of the Employee Retirement Security Act of 1974, at 1335-1836 (Comm. Print 1976). The hearing examiners would have presided over trial-like evidentiary hearings, which would have been governed on appeal by the Administrative Procedure Act. *Id.* Because Congress did not adopt this approach, it is permissible for plan decisions to be rendered by conflicted adjudicators. *Id.* at 1838. What is not permissible is for the federal courts to treat challenges to such decisions as if they had been rendered with the safeguards provided by federal administrative agencies.

1973) (noting that courts of equity traditionally exercise broad supervision over trustees). Indeed, it is one of the distinctive characteristics of ERISA that all of its remedies are in their essence equitable. *Sullivan v. LTV Aerospace and Defense Co*, 82 F.23 1251, 1258 (2d Cir. 1996); *cf. Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). As a corollary, district courts are presumptively required to review plan decisions with the high level of care that courts of equity exercise when they review the decisions of trustees, rather than with the deference ordinarily provided the actions of government agencies. *Firestone*, 489 U.S. at 111. In accordance with principles of trust law, this duty is heightened when a court reviews the decision of an insurer subject to financial interests conflicting with those of a participant or beneficiary; in such cases, a court may provide the decisionmaker with the least degree of deference or no deference at all. Restatement (Second) of Trusts § 170(1) cmts. a-h (1959); *id.* at § 187.

II. Failure To Resolve The Problem Raised By Petitioner Risks Further Erosion Of Public Confidence in ERISA-Governed Benefit Plans To Provide Promised Benefits

The principal problem ERISA was intended to remedy was the unexpected and unfair loss of benefits. *Rettig v. PBGC*, 744 F.2d 133, 135-36 & n.2 (D.C. Cir. 1984) ("Congress sought to remedy the predicament of thousands of employees whose expectations of adequate retirement income were destroyed by stingy pension plan provisions, bad management or inadequate funding."); *Duchow v. New York State Teamsters Conf. Pension & Ret. Fund*, 691 F.2d 74, 76 (2d Cir. 1982) ("ERISA was designed to reduce, by various means, the number of pension benefits lost."). The rule challenged by Petitioner patently subverts that goal. Employee benefits are not

gratuities. When ERISA-regulated plans promise that benefits will be paid under specified circumstances, such as the reaching of retirement age or becoming disabled, an employee or beneficiary to whom the promise has been made has the right to expect that the benefit will be paid. *Firestone*, 489 U.S. at 113.

Inherent in fulfilling that expectation is the requirement that any dispute about whether those circumstances actually exist will be adjudicated fully and fairly. 29 U.S.C. § 1133. Employees and their beneficiaries cannot be expected to view an adverse benefit determination rendered by a conflicted adjudicator as fair. The unfairness of conflicted adjudication is obvious to them. It was implicit in the lesson taught to them as children when their teachers explained the necessity for an independent judiciary; it is consistent with their common sense and their common experience. And it is, of course, implicit in, and consistent with, the codes of conduct to which judges themselves are subject, codes that not only prohibit decisions tainted by conflicts of interests but decisions that even have the appearance of being so tainted. *See* ABA Model Code of Judicial Conduct, Canon 2, Comment ("A judge must avoid all impropriety and appearance of impropriety."); *id.*, Canon 5(C)(1) ("A judge should refrain from financial and business dealings that tend to reflect adversely on his impartiality . . . .").

The confidence of workers and their dependents is not mitigated by knowledge that, if they are somehow able to "prove" by external evidence that the conflict of interest affected the decision, the courts will provide less deferential review. Their knowledge of this theoretical possibility is eclipsed by their knowledge that, as a practical matter, uncovering the specific evidence needed to meet this burden will almost always be impossible. This is amply demonstrated by a review of cases decided by the Second Circuit and by the district courts thereunder. From the time the rule in *Pagan* was

adopted ten years ago to October 12, 2005, there have been 33 such cases whose ultimate outcome has been published.[7] In only one of these cases did the court actually find that less deferential review was merited because the plaintiff had made a showing that the conflict had affected the adverse decision; the one successful plaintiff was an attorney at the law firm Paul, Weiss,

---

[7] *Smith v. First UNUM Life Ins. Co.*, 2005 WL 2475724 (2d Cir. 2005); *Waksman v. IBM Separation Allowance Plan*, 138 Fed. Appx. 370 (2d Cir. 2005); *Kirk v. Readers Digest Assoc.*, 57 Fed. Appx. 20 (2d Cir. 2003); *Caidor v. Chase Manhattan Bank*, 29 Fed. Appx. 704 (2d Cir. 2002); *Parry v. SBC Communications, Inc.*, 375 F. Supp.2d 31 (D. Conn. 2005); *Badawy v. First Reliance Standard Life Ins. Co.*, 2005 WL 2396908 (S.D.N.Y. 2005); *Nerys v. Building Services*, 2004 WL 2210256 (S.D.N.Y. 2004); *Owen v. Wade Lupe Construction Co.*, 325 F. Supp.2d 146 (N.D.N.Y. 2004); *Chan v. Hartford Life Ins. Co.*, 2004 WL 2002988 (S.D.N.Y. 2004); *Snyder v. First Unum Life Ins. Co.*, 2004 WL 1784334 (W.D.N.Y. 2004); *Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111 (S.D.N.Y. 2004); *Wagner v. First Unum Life Ins. Co.*, 2003 WL 21960997 (S.D.N.Y. 2003); *Shutts v. First Unum Life Ins. Co.*, 310 F. Supp.2d 489 (N.D.N.Y. 2004); *Doe v. Cigna*, 304 F. Supp.2d 477 (W.D.N.Y. 2003); *Bergquist v. Aetna U.S. Healthcare*, 289 F. Supp.2d 400 (S.D.N.Y. 2003); *Armstrong v. Liberty Mutual Life Assur. Co.*, 273 F. Supp.2d 395 (S.D.N.Y. 2003); *Henar v. First Unum Life Ins. Co.*, 2002 WL 31098495 (S.D.N.Y. 2002); *Maniatty v. Unumprovident Corp.*, 218 F. Supp.2d 500 (S.D.N.Y. 2002); *Rosenthal v. First Unum Life Ins. Co.*, 2002 WL 975627 (S.D.N.Y. 2002); *Thompson v. General Elec. Co.*, 2002 WL 482862 (S.D.N.Y. 2002); *Zervos v. Verizon New York, Inc.*, 2001 WL 1262941 (S.D.N.Y. 2001), *rev'd on other grounds*, 277 F.3d 635 (2d Cir. 2002); *Schwartz v. Oxford Health Plans*, 175 F. Supp.2d 581, 590-91 (S.D.N.Y. 2001); *Corvi v. Eastman Kodak Co. Long Term Disability Plan*, 2001 WL 484008 (S.D.N.Y. 2001); *Flynn v. Hach*, 138 F. Supp.2d 334 (E.D.N.Y. 2001); *Roberton v. Citizens Utilities Co.*, 122 F. Supp.2d 279 (D. Conn. 2000); *Risenhoover v. Bayer Corp.*, 83 F. Supp.2d 408 (S.D.N.Y. 2000); *Administrative Committee of the Time Warner, Inc. v. Biscardi*, 2001 WL 286749 (S.D.N.Y. 2000); *Montesano v. Xerox*, 117 F. Supp.2d 147 (D. Conn. 2000); *Boesel v. The Chase Manhattan Bank*, 62 F. Supp.2d 1015 (W.D.N.Y. 1999); *Weissman v. First Unum Life Ins. Co.*, 44 F. Supp.2d 512 (S.D.N.Y. 1999); *DeVere v. Northrop Grumman Corp.*, 1999 WL 182670 (E.D.N.Y. 1999); *Elsroth v. Consolidated Edison*, 10 F. Supp.2d 427 (S.D.N.Y. 1998); *Semmler v. Metropolitan Life Ins. Co.*, 172 F.R.D. 86 (S.D.N.Y. 1997).

Rifkind, Wharton & Garrison. *Schwartz v. Oxford Health Plans*, 175 F. Supp.2d 581, 590-91 (S.D.N.Y. 2001) (finding a conflict of interest that affected the denial of benefits where insurer had recently announced large operating losses, repeatedly advised claimant to use an in-network provider, failed to explain its decision to the claimant, and offered weak arguments in support of its position). These numbers, of course, do not indicate the full scope of the problem, since the generally insurmountable burden of proof has undoubtedly discouraged many plaintiffs from even raising the issue. This is especially so given that the evidence necessary is by definition in the sole possession of the insurer, and uncovering such a conflict of interest requires significant resources well beyond the means of the disabled or elderly workers and their dependents for whose benefit ERISA was enacted. *See generally* Peter A. Meyers, Comment, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 Seattle L. Rev. 925, 925-927 & nn.5 & 16 (2005) (and sources cited therein).[8]

The loss by employees and their dependents of faith in the system of ERISA-regulated benefit plans to provide

---

[8] In addition to recounting the difficulties in ERISA plaintiffs gathering sufficient evidence to show a conflict, Peter A. Meyers describes the widespread national media coverage of the abusive practices of the largest disability insurer in the nation—attention that has surely shaken faith in the private disability benefits system. *Id.* at 925 n.5. *See generally* Peter G. Gosselin, *State Fines Insurer, Orders Reforms in Disability Cases*, Los Angeles Times, Oct. 3, 2005, at A1; Peter G. Gosselin, *The New Deal; The Safety Net She Believed In Was Pulled Away When She Fell*, Los Angeles Times, August 21, 2005, at A1; *Did Insurer Cheat Disabled Clients?*, 60 Minutes, CBS News, Nov. 17, 2002, *available at http://www.cbsnews.com/stories/2002/11/15/60minutes/main529601.shtml*; John Larson & Lea Thompson, *Benefit of the Doubt; Several People Accuse Insurance Company UnumProvidence [sic] of Searching for Reasons to Deny Claims*, Dateline NBC, Oct. 12, 2002, *available at* LEXIS, NEWS-ALL database.

promised benefits has brought with it another problem: a loss of faith in the willingness and capacity of the government to ensure their fair treatment. By all but proclaiming indifference to whether or not a plan adjudication by a conflicted administrator was actually correct, *see, e.g.*, *Mers v. Marriot Int'l Group Accid. Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), the Seventh Circuit exacerbates the continued loss of faith by employees and their dependents in ERISA's ability to serve its aim of eliminating abuses in the distribution of benefits. Announcing the irrelevance of fairness in this case—despite the presence of a irreconcilable conflict of interest that prevented a "fair" decision by the ERISA insurer—the court below stated that it was unconcerned with whether Petitioner was actually eligible for the benefits he was denied because, in the court's view, "[u]nder the arbitrary and capricious standard we do not ask if the administrator reached the correct decision or even whether it relied upon the proper authority." *Kobs*, 400 F.3d at 1039. Needless to say, such proclamations of indifference to fairness can only work to undermine public belief that the enforcement of ERISA does justice.[9]

---

[9] The fair administration of pension plans is not merely a concern of their participants and beneficiaries. The entire tax-paying public has a direct interest in ensuring that the federal courts make full use of their equitable powers when reviewing suits by claimants whose benefits have been denied without the benefit of an independent decisionmaker and without the judicial-type safeguards that are at the core of the Anglo-American system of justice. Of particular concern to the public, these biased adjudications are made by plans that reap considerable benefits as a result of tax exclusions under Title I of the Internal Revenue Code. The price paid by the Treasury Department is significant. The loss of otherwise taxable income in 2003 due to exclusions relating to employer and individual contributions to retirement and health plans, respectively, is estimated at $279.1 billion and $569.9 billion. Majority Staff of the House Comm. on Ways and Means, 108th Cong. 2d sess., 2004 Green Book, Background Material on Data on the Programs Within the Jurisdiction of the Committee on Ways and Means Table 13-2 (Comm. Print Mar. 2004),

This loss of public faith is hardly restored when judges themselves lament that "ERISA has gone conspicuously awry from its original intent" and "has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect." *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 56, 65 (D. Mass. 1997) (Young, J.). Nor is confidence bolstered when a panel of judges in the Second Circuit, despite acknowledging the binding nature of prior precedent, went so far as to announce that *Pagan* "fail[ed] to give weight to" this Court's instruction in *Firestone* that a conflict of interest should be "weighed as a factor" in judicial review. *DeFelice v. American Int'l Life Assurance Co.*, 112 F. 3d 61, 66 (2d Cir. 1997) (quoting *Firestone*, 489 U.S. at 115).

The importance that people not only be treated fairly but also have confidence in the government's capacity to act, if necessary, to make sure they are treated fairly, has been explained by Justice Frankfurter:

> The heart of the matter is that democracy implies respect for the elementary rights of men, however suspect or unworthy; a democrat government must therefore practice fairness; and fairness can rarely be obtained by secret, one-sided determination of facts decisive of rights. . . . Man being what he is cannot safely be entrusted with complete immunity from outward responsibility in depriving others of their rights. . . . The validity and moral authority of a conclusion largely

---

available at http://www.gpoaccess.gov/wmprints/green/2004.html. To say the least, it was not Congress's intention that conflicted plans be permitted to reap the benefits of tax qualification—by being paid in more valuable pre-tax dollars—while the employees and their beneficiaries for whose protection ERISA was enacted are denied redress to independent courts that will impartially exercise their full equitable powers to ensure that participants and beneficiaries actually receive the benefits for which they are eligible.

> depend on the mode by which it was reached . . . . "In a government like ours, entirely popular, care should be taken in every part of the system, not only to do right, but to satisfy the community that right is done."

Joint Anti-Fascist Refugee Committee v. McGrath, 341 U.S. 123, 170-172 & n.19 (1951) (Frankfurter, J., concurring) (quoting 5 *The Writings and Speeches of Daniel Webster* 163) (other citations and footnotes omitted).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

GARY STONE
Counsel of Record
JONATHAN A. WEISS
LEGAL SERVICES FOR THE ELDERLY
130 West 42nd Street
17th Floor
New York, New York 10036-7803
(646) 442-3316

October 28, 2005

4

No. 05-394

IN THE

Supreme Court of the United States

ELVIS KOBS,

Petitioner,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

REPLY BRIEF FOR THE PETITIONER

LAURA W. BRILL
Counsel of Record
TED M. SICHELMAN
IRELL & MANELLA, LLP
1800 Avenue of the Stars
Los Angeles, California
90067
(310) 277-1010

JASON W. WHITLEY
NOVITZKE, GUST, SEMPF
& WHITLEY
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
(715) 268-6130

Counsel for Petitioner Elvis Kobs

November 14, 2005

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases:

Page(s)

I. UWIC Does Not Dispute The Key Factors That Make This Case Worthy Of Certiorari

Respondent UWIC's Brief in Opposition to the Petition for Certiorari ("Opp.") is notable for its failure to contest the numerous factors that make this case an ideal vehicle for review. For example, UWIC makes no attempt to contest that the questions presented concern deeply entrenched splits among the circuits on matters of significant national importance that need to be resolved by this Court. Nor does UWIC contest that it is a "dual-role" insurer.[1] Finally, UWIC does not dispute that the judgment of the Seventh Circuit is final, that the medical evidence is in conflict, or that the Seventh Circuit expressly stated that its "deferential" standard of review was material to its decision. Opp. 5-9, 12-13.

Rather than disputing these key factors, UWIC goes to great lengths to cloud the issues, concocting arguments that are largely irrelevant to whether the petition should be granted. In so doing, UWIC distorts the proceedings below, ignores the procedural posture of this case, posits impossible hypotheticals, and mischaracterizes the possible outcomes of a decision by this Court. As explained in more detail below, none of UWIC's arguments establishes any true "vehicle problem" with this case.[2]

---

[1] *See* Opp. 3 (noting that disability plan was "administered and insured by Respondent"). *See also* Pet. App. 34a, 40a (plan documents); *id.* at 15a (district court noting that "defendant acted as both plan administrator and insurer"); *id.* at 5a (circuit court analyzing effect of UWIC's "dual role").

[2] This case has none of the substantive or procedural flaws of the other cases relating to conflicted ERISA insurers that this Court has recently declined to address. *See, e.g.*, Petition for Certiorari, *Merck & Co., Inc. v. Epps-Malloy*, *cert. denied*, 125 S. Ct. 2252 (May 16, 2005) (No. 04-995), 2005 WL 175921 (focusing on relationship

II. This Court Should Not Defer Resolution Of The Important Questions Presented In This Case Pending The Advent Of UWIC's Hypothetical "Ideal" Vehicle

This case raises two significant questions: First, whether the dual role of an ERISA fiduciary insurer constitutes an inherent conflict of interest that must be considered in the judicial review of denials of claims; and, second, if the answer to the first question is "yes," what is the appropriate means to consider the conflict of interest. UWIC argues that this Court should refrain from resolving either question unless it is faced with a case in which it is certain to be able to answer both. Opp. 13. UWIC is misguided.

Importantly, UWIC does not deny that if this Court were to answer "yes" to the first question presented, then this Court could reach the second question. *See* Opp. 13, 19-23. Moreover, the first question presented is itself a matter of substantial national importance on which circuit courts are hopelessly divided. Pet. 10-13. Answering this question alone will provide important guidance to federal courts that consider thousands of ERISA cases per year involving dual-role insurers. *Id.* at 22-25. Thus, this issue should be resolved whether or not the Court is able to reach the second question in the same case. The policies of ERISA demand a uniform rule: either an inherent conflict is sufficient to be considered in

---

between independent medical examinations and general conflicts of interest, as opposed to inherent conflicts of interest); *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir.) (non-final decision containing complex, tangential issues), *cert. denied*, 125 S. Ct. 1972 (May 2, 2005); Petition for Certiorari, *Peach v. Ultramar Diamond Shamrock*, *cert. denied*, 125 S. Ct. 1641 (Mar. 21, 2005) (No. 04-919), 2004 WL 3057828 (presenting (1) vague question whether different standards of review in conflict cases are inconsistent with goals of ERISA, and (2) fact-specific question of whether ERISA administrator's decision was actually "arbitrary and capricious").

judicial review of benefits denials or it is not. *Id.* at 10-13. *See generally Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488, 2495 (2004) (noting that the "purpose of ERISA is to provide a *uniform* regulatory regime over employee benefit plans") (emphasis added). UWIC does not argue that there are any barriers to this Court's consideration of the first question presented.

In addition, there will never be a case in which the first question is squarely before the Court and in which the Court can be assured of reaching the second question. Specifically, if this Court were to decide the first question and find that an insurer's dual role does not constitute a conflict of interest to be considered in judicial review, and in any such case the claimant had not obtained evidence of a conflict beyond the fact of the dual role, this Court would never reach the second question. Conversely, any case with substantial additional evidence of a conflict beyond the insurer's dual role would not be a proper vehicle to resolve the first question. In such a case, although the Court could reach the second question, any ruling on the first question—i.e., whether the dual role, *alone*, should be considered in the judicial review of claim denials—would be mere dicta. Thus, UWIC's hypothetical "ideal" case is merely "imaginary."

In a related argument, UWIC contends that this case is not an ideal vehicle because Petitioner did not appeal from the district court's order denying him the opportunity to take discovery. This contention is irrelevant to the questions presented. It is important to understand the limited scope of UWIC's waiver argument. UWIC contends that "[i]f this Court rules that an ERISA claimant is required *to prove something more than an 'inherent' conflict* in order to modify the abuse of discretion standard, such a decision will make no difference in this case because Petitioner has not preserved his opportunity to meet this standard." Opp. 21 (emphasis added). In other words, UWIC is arguing

that if this Court answers the first question presented in the negative, then this Court will not reach the second question presented, and there will be no remand. Assuming UWIC were correct, that would hardly be a reason not to grant the petition in this case, because the first question alone is worthy of certiorari.

In addition, UWIC does not dispute that if this Court answers the first question presented in the affirmative, then further discovery on remand may well be appropriate in order to apply whatever legal standard this Court may announce. *See, e.g., Johnson v. California*, __ U.S. __, 125 S. Ct. 1141, 1152 (2005) (adopting more stringent standard of review than lower court and remanding for determination under new standard); *id.* at 1172 (Thomas, J., joined by Scalia, J., dissenting) (noting that because losing party was subject to a more stringent standard of review, it should, upon remand, "be allowed to present evidence of narrow tailoring, evidence it was never obligated to present in either appearance before the District Court"). *See also Rengers v. WCLR Radio Station, a Div. of Bonneville Intern. Corp.*, 825 F.2d 160, 165 (7th Cir. 1987) ("[D]efendant's failure to object waived its right to challenge the instruction as incorrect in view of other Circuits' decisions, but it did not act as a waiver to challenge the instruction on the basis of an intervening Supreme Court decision and consequent change in the law.").

III. Whether Petitioner Presented Evidence Of A Conflict Beyond Respondent's Dual Role Is Irrelevant To Whether Respondent Has An Inherent Conflict Of Interest

UWIC additionally contends that the district court and Seventh Circuit "carefully considered the potential for bias" by examining the specific facts in the record in this case. Opp. 1, 14-19. This argument again overlooks

the questions presented and mischaracterizes the Seventh Circuit's opinion.

In particular, the first question presented in this case is whether a dual-role insurer "*inherently* acts under a conflict of interest to be considered in the judicial review of a denial of benefits." Pet. i (emphasis added). This question asks whether, *based solely on an insurance company's dual-role status*, there is a conflict of interest to be considered in judicial review. Evidence regarding UWIC's procedures does not address this question or alter its importance. Moreover, there was no conclusion by the Seventh Circuit that UWIC's procedures demonstrated that its decision was uninfluenced by its conflict of interest. Rather, the Seventh Circuit presumed that there was no conflict and placed the burden on Mr. Kobs to rebut that presumption. Pet. App. 5a-6a.

In addition, depending upon the appropriate test used to consider the conflict of interest, evidence of the procedures of an inherently conflicted insurer may, as a matter of law, be insufficient to rebut a finding that there was a conflict. *E.g.*, *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997, 1004-06 (10th Cir. 2004) (adopting irrebuttable presumption of a conflict of interest based on inherent conflict of an insurer). Because this Court has not yet determined what test should apply, it is premature to assess how UWIC's procedures may be weighed in this case.

In asserting that it acted without bias, UWIC argues that the Seventh Circuit employs a fact-specific test and "refuses to engage in general assumptions about insurer bias." Opp. 16. UWIC misreads Seventh Circuit case law. Far from avoiding economic assumptions, the Seventh Circuit's legal standard presumes that dual-role insurers, which have structural financial incentives to act

against the interests of beneficiaries, will not do so.[3] The Seventh Circuit makes further policy assumptions in placing the burden on ERISA beneficiaries, who are by definition likely to be sick or otherwise vulnerable, to develop evidence on a case-by-case basis of information about bias that is typically in the sole possession of the insurer. The majority of circuits addressing conflicts of dual-role insurers do not agree that the economic realities or the policies of ERISA justify allocating burdens in this way. Pet. 10-11.

Petitioner's evidence regarding the practices of other insurance companies, Pet. 26-27, underscores the error of the Seventh Circuit's standard and supports the conclusion of the majority of circuits that the financial interests of insurance companies create significant recurring incentives for insurers to engage in self-serving behavior. Indeed, UWIC acknowledges that "insurers are in business to make a profit and it is not impossible that there may be a temptation in some cases to deny borderline claims." Opp. 14-15.

Accordingly, the professed "neutrality" of UWIC and its interpretation of the Seventh Circuit's rule do not provide a basis for denying the petition for certiorari.

IV. The Standard Of Review Is Outcome Determinative Of The Decision Below

UWIC devotes ten pages to a fact-intensive "Counterstatement of the Case" and spends another six pages arguing that Mr. Kobs would lose below under any

---

[3] *See, e.g., Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020-21 (7th Cir. 1998) ("The impact of granting or denying benefits in this case is minuscule compared to AIG's bottom line."). *Cf. Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000) ("insurance carriers have an active incentive to deny close claims in order to keep costs down . . . , an economic consideration overlooked by the Seventh Circuit").

test. Opp. 3-13, 23-28. Despite the length of its argument, UWIC does not dispute that genuine issues of material fact exist in this case. On the orthopedic issues, for example, two examining physicians support Mr. Kobs's position and one supports UWIC's position; on the cognitive issues, two examining physicians support Mr. Kobs's position and two support UWIC's position.[4] Thus, UWIC's position that granting it summary judgment would be appropriate under any test that this Court might adopt is simply wrong. In fact, the Seventh Circuit specifically noted the importance of the standard of review in reaching its result. Pet. App. 9a.

As an initial matter, UWIC misreads this Court's holding in *Firestone* to conclude that *de novo* review is never appropriate to review decisions of conflicted administrators. Although this Court held in *Firestone* that an "abuse of discretion" standard must be applied when a plan grants discretionary authority to an ERISA administrator or fiduciary, this does not preclude that

---

[4] UWIC noticeably omits Dr. Melby's diagnosis of "memory loss," Pet. App. 55a-56a, from its discussion regarding Petitioner's "psychiatric/psychological complaints." Opp. 6-9. Moreover, the assertion that "at least three experts determined that Petitioner was 'sandbagging' during testing, including a neuropsychologist who tested Petitioner on a referral from Petitioner's own doctor" is distortion and hyperbole. Opp. 2. First, Dr. Mary Sullivan, the psychologist who saw Mr. Kobs on referral, diagnosed Mr. Kobs with a "psychological disturbance . . . which would render it difficult for him to be a fully engaged worker." Pet. App. 79a. Dr. Sullivan also noted that she believed Mr. Kobs's "performance" on her evaluations "raise[d] questions about the effort he exerted," but she remarked that "these efforts . . . were *not done deliberately*, e.g., with the intent to deceive." *Id.* at 77a-78a (emphasis added). Dr. Philip Sarff, a psychologist hired directly by UWIC opined that Mr. Kobs "consciously or unconsciously exaggerated symptoms." *Id.* at 85a. These statements are hardly findings of "sandbagging." Finally, Nurse Francine Blaha's incomplete recounting of Dr. Sullivan's and Dr. Sarff's reports can scarcely be termed a diagnosis. *Id.* at 91a. UWIC's "sandbagging" mantra also fails to recognize the gravity of Mr. Kobs's losses. Forfeiture of one's home and car are far from the acts of a "sandbagger." Pet. 5.

standard from effectively becoming a *de novo* standard in certain instances. In particular, four circuits hold that when an ERISA administrator acts under a conflict of interest, there should be no deference given to the administrator. The result is that these circuits examine the denial of benefits under an effective *de novo* standard.[5] This is consistent with black-letter trust law, which allows a court to "void" a decision of a trustee administering a trust under a conflict of interest. *See* Restatement (Second) of Trusts § 170(1) cmts. a-h (1959); *id.* at § 187. Under any of these circuits' approaches, UWIC would not have been entitled to summary judgment in the face of genuine issues of material fact in dispute. *E.g.*, *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 978 (9th Cir. 1999) (applying *de novo* standard that deems conflicted decisions to be "presumptively void," and holding that "[b]ecause there are genuine issues of material fact in dispute as to whether Tremain was disabled and as to whether she was a 'salesman,' her entitlement to benefits and the amount of those benefits may not be decided by summary judgment").[6]

Finally, UWIC contends that even if summary judgment in its favor was not appropriate, Petitioner would lose at trial, because summary judgment in the ERISA context is equivalent to a trial. This assertion again misstates the law. As noted above, if this Court

---

[5] *Fought*, 379 F.3d at 1004-06; *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996); *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990).

[6] Even under a sliding scale test, following further discovery below, it is likely that summary judgment would not be appropriate. *E.g.*, *Pinto*, 214 F.3d at 393-95 (finding that summary judgment was inappropriate under a sliding scale approach where physicians' opinions conflicted and "a factfinder could conclude that [the insurer's] decision to credit its doctors . . . was the result of self-dealing instead of the result of a trustee carefully exercising its fiduciary duties").